Transplant

REFERRAL FORM

Phone: 818-390-9696 Toll-free: 855-265-7850 ● Fax: 818-804-3492 Toll-free fax: 855-450-6717 ● info@MedicoRX.com

Patient information		Prescriber information	
Name:	**DOB:**	**Prescriber's Name:**	
Address: **City, State, Zip**		**NPI#**	
		DEA#	**License#**
Phone #	**Alt#**	**Address** **City, State, Zip**	
SSN:			
Height:	**Wt:**	**Phone #**	**Fax #**
Allergies:			
Emergency Contact/ Phone #		**Contact Person:**	

Clinical Assessment: Please fax recent clinical notes, labs and tests to expedite the Prior Authorization Process

ICD-9 Code:

ICD-10 Code/ Diagnosis_____

Transplant Type:

□ Heart □ Kidney □ Lung □ Pancreas □ Other _____ Date of transplant: _____

Test Results:

□ SCr/CrCl _____ WNL: □ Yes □ No

□ LFTs _____ WNL □ Yes □ No

Medication	Dose/Strength	Directions for Use	Quantity	Refills
□ Prograf (tacrolimus) □ Hecoria (tacrolimus)	□ **0.5mg** □ **1mg** □ **5mg**			
□ Gengraf (cyclosporine) □ Sandimmune (cyclosporine) □ Neoral (cyclosporine)	□ **25mg** □ **100 mg**			
□ CellCept (mycophenolate mofetil) □ Myfortic (mycophenolic acid)	□ **250mg** □ **500mg** □ **180mg** □ **360mg**			
□ Rapamune (sirolimus)	□ **1mg** □ **2mg**			
□ Zostress (everolimus)	□ **0.25mg** □ **0.5mg** □ **0.75mg**			
□ Prednisone	□ **5mg**			
□ **Nulojix** (belatacept) **IV infusion**	□ **250mg vial**			
□ **Simulect** (basiliximab) **IV infusion**	□ **10mg vial** □ **20mg vial**			
□ **Atgam** (lymphocyte immune globulin, anti-thymocyte globulin) **IV Infusion**	□ **250mg/5ml vial** □ **250mg/5-5ml ampoules**			
PCP Prophylaxis _____ CMV Prophylaxis _____ Thrush (candida) _____ **Other**				

By signing this form I authorize MedicoRX and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

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Prescriber's signature (no stamps) if brand required check this ☐ DAW___ **Date**